



# ARIS Solutions

ARIS SOLUTIONS  
 White River Junction, VT 05001  
 Phone 866.970.3301  
 Fax 802.295.9812  
[veteranpayroll@arissolutions.org](mailto:veteranpayroll@arissolutions.org)

Financial & Payroll Services for the Nonprofit Sector

## Enrollment Forms for:

### **Indiana Generations** VD-HCBS Program Employers

This packet contains the necessary forms and instructions that will authorize ARIS Solutions to act in your behalf as your FMS provider.

\*\*ALL FORMS MUST BE SIGNED/DATED AND RETURNED TO ARIS SOLUTIONS\*\*

- ☐ Employer Confirmation of Receipt
- ☐ Fraud & Abuse Statement
- ☐ HIPAA Notice of Privacy Practices & Agreement
- ☐ Customer Grievance Policy
- ☐ Employer / Participant Information Form
- ☐ Form SS-4 - Application for Employer Identification Number
  - ❖ Allows ARIS to request a Federal Employer Identification Number from the IRS for you.
- ☐ Form 2678 - Employer/Payer Appointment of Agent
  - ❖ Allows ARIS to file your employment tax forms.
- ☐ Form 2848 - Power of Attorney and Declaration of Representative
  - ❖ Allows ARIS to speak to the IRS and Indiana Department of Workforce Development on your behalf.
- ☐ Form 8821- Tax Information Authorization
  - ❖ Allows ARIS to receive & review copies of tax filings from the IRS.
- ☐ State Tax Forms
  - ❖ SUTA Account Number Application (State Form 2837)- to setup an account with the Indiana Department of Workforce Development
  - ❖ Indiana Dept. of Revenue
    - Form BT-1 Tax Registration - To apply for a withholding tax number for the State of Indiana.
    - "Power of Attorney" allows ARIS to speak to the Department of Revenue on your behalf and file all quarterly withholding tax forms.
- ☐ Indiana County Tax (IN County Recorders Telephone Numbers)
  - ❖ Register with Local County Recorders Office and send to ARIS.

### Return Packet to: ARIS Solutions-Veteran Program

**PO Box 4409**  
**White River Jct., VT 05001**  
**Phone: 866.970.3301 (toll free)**  
**Fax: 802.295.9812**  
**Email: [veteranpayroll@arissolutions.org](mailto:veteranpayroll@arissolutions.org)**



## New Employer/Participant Information

### You are now an Employer!

Welcome to the Veteran Directed Home and Community Based Services Program employment model. You will now manage and direct the services you receive or the services the Veteran you represent receives. In this employer model you, or a representative who you appoint, are the employer and you direct the work of your employee. (Please read the New "Employer/Participant" handbook for more details of the Employers role in the VD-HCBS Program)

### The Role of ARIS Solutions as Your FMS Provider

ARIS Solutions will serve as your FMS Provider to support you and complete many of the administrative employer obligations. This means that ARIS will process your timesheets, conduct criminal background checks on potential employees manage your employer tax responsibilities on the federal and state level, apply for workers compensation insurance, and pay your employees.

### Roles and Responsibilities Chart

<b>Your Role</b> <i>(as Employer)</i>	<b>Employee's Role</b> <i>(as Employee)</i>	<b>ARIS Solutions' Role</b> <i>(as FMS Provider)</i>
Select and hire an employee  Schedule employees (staying within your authorized budget)  Train employees  Sign timesheets  Review employees job performance	Meet your requirements for hiring  Complete required employment paperwork  Pass a background check  Submit signed timesheets to ARIS	Assist with paperwork, as needed  Establish you as an employer  Establish your worker as your employee  Conduct criminal background checks
Dismiss employees  Establish clear boundaries  Let your employee know what the rules are and what their responsibilities are  Prevent fraud	Respect employer's boundaries, rules and responsibilities  Provide home care services to your employer as directed by your employer  Prevent fraud	Provide payroll services Prepare and disburse payroll checks  Pay employer taxes  Prepare year-end tax reports  Apply for and secure Workers Compensation insurance on behalf of the employer

### *The hiring process*

ARIS Solutions will assist you, as needed, with all of the paperwork necessary to establish you as an employer and establish your worker as your employee.

### *Payroll services*

ARIS Solutions will prepare and disburse payroll checks and year-end tax statements. In addition, ARIS will pay all employer taxes, withhold employee taxes, and submit tax withholding statements to the appropriate government agencies. If your employee ever needs employment verification ARIS will handle that as well, just forward the request via fax/email/ mail.

### Contact Information

You can remove this page from the packet and post it somewhere prominent so you always have the information you need to contact the resources you need.

ARIS Solutions-Veteran Program staff is available for support Monday through Friday from 8:00 am to 4:00pm (EST) and can be reached at **866.970.3301** (toll free).

*ARIS Solutions is not open on state or federal holidays.*

### Veteran Program Team

Topic	Resource	Contact Info
Veteran Program Director	Theresa Danforth	<a href="mailto:theresad@arissolutions.org">theresad@arissolutions.org</a>
Veteran Program Specialist *Employer questions/concerns	Emilie Donka	<a href="mailto:emilied@arissolutions.org">emilied@arissolutions.org</a>
Veteran Program Payroll Specialist (s)	Megan Whiton Janet Allen	<a href="mailto:meganw@arissolutions.org">meganw@arissolutions.org</a> <a href="mailto:janeta@arissolutions.org">janeta@arissolutions.org</a>



ARIS Solutions  
Financial & Payroll Services for the Nonprofit Sector



# ARIS Solutions

## PROGRAM INTEGRITY and FRAUD PREVENTION

Maintaining and improving program integrity is one of the most important aspects of the Veteran Directed Program. Program integrity including fraud prevention is critical to sustaining this program model. Participants, authorized representatives, and providers are vital to preventing fraud and maintaining program integrity.

Fraud and abuse with funds from the Veteran's Administration can cost billions of dollars each year, diverting funds that could otherwise be used for additional services or to assist more people that need care. As a participant, authorized representative, care provider or recipient of funds, you must comply with all State and Federal laws and prevent misuse or fraud of any funds within this programs. Honesty and integrity are expected of all who participate in the Veteran Directed Program. (Please refer to the New "Employer/Participant" Handbook for more detail on fraud within the Veteran Directed Program)

### Definition

Fraud is to intentionally misrepresent, cheat or deceive in order to benefit or gain something of value. Medicaid fraud is knowingly falsifying or misrepresenting the truth to obtain unauthorized benefits. Abuse includes any practice inconsistent with acceptable practices that will unnecessarily increase costs.

### *Examples of Fraud and Abuse Include*

- Submitting timesheets for services not actually provided
- Approving/authorizing hours that employees didn't actually work
- Recording more time or stating different times than you actually work
- Changing hours on a timesheet after it has been approved
- Not providing the services the participant needs
- Falsifying a worker's compensation claim
- Falsifying or misrepresentation on applications or documentation
- Billing for services while in the hospital or other care facility
- Submitting twice for the same service
- Requiring an employee to "share" their paycheck with the employer

### Results

Fraud is a felony conviction that can lead to substantial penalties, including imprisonment up to then years, or a fine of up to \$1,000 or an amount equal to twice the amount of assistance or benefits wrongfully obtained, or both. If convicted of fraud you may be excluded for a minimum of five year from any employment with a program or facility that receives Medicaid funding.

### **REPORTING**

If you suspect or know of fraud or abuse occurring, it is your duty and responsibility to report this immediately to the Association of Area Agency and the Veteran's Administration. Or call ARIS Solutions at 802.280.1911 and the proper people will be contacted.



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**Employer Confirmation of Receipt**

I, \_\_\_\_\_, have read the "New Employer/Participant" Handbook and "Program Integrity and Fraud Prevention" documents provided by ARIS Solutions.

I understand and accept my role or my designated representative's role as an employer in the Veteran Directed Program employment model.

I acknowledge that I am the employer of any employee I may choose to hire to provide home health care service in the Veteran Directed Program employment model.

I understand I am responsible for hiring, firing, training, and supervising my employees, as well as, maintaining program integrity by preventing and reporting fraud.

I understand and acknowledge that as a FMS Provider, ARIS Solutions, **will not** act as the employer of any employee I may choose to hire through this program.

Signed,

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## FRAUD & ABUSE STATEMENT

**Fraud** is defined as **recklessly or purposefully** making false statements or representations to obtain some benefit or payment that you would not be entitled to without those statements or facts. These acts may be committed either for the person's own benefit or for the benefit of someone else. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of facts. Fraud is committed when a person or business deceives or distorts facts or information to get something they would not be otherwise entitled to. Fraud can range from a solo act to a broad-based operation by an institution or a group. Anyone can commit fraud.

**Examples of Medicaid/Veteran Administration Fraud include, but are not limited to:**

- Knowingly and/or purposefully filling out an employee timesheet incorrectly for hours or services that were not provided during the times listed or on the day listed;
- Knowingly and/or purposefully allowing the Vendor F/EA FMS-Support Broker entity to bill Medicaid/Veteran Administration for services that were not provided;
- Knowingly and/or purposefully using the Veteran's budget for any other purpose than what has been approved in the Veteran's service plan.
- Knowingly and/or purposefully allowing an employee to document services or hours that were not provided.
- Knowingly and/or purposefully submitting invoices to the Vendor F/EA FMS-Support Broker entity for goods and services that were not provided.
- Knowingly and/or purposefully having the Vendor F/EA FMS-Support Broker entity pay an employee or vendor for goods and/or services actually provided by someone else. (This is also tax fraud.)
- Knowingly and/or purposefully making a "side deal" with an employee to split their pay check with the Veteran or his/her representative. (This is also tax fraud).
- Knowingly or purposefully withholding information from authorities during an investigation
- Knowingly and/or purposely having the Vendor F/EA FMS-Support Broker entity pay for an approved good included in the Veteran's budget, and then return the approved good to get the cash or use it for something else that has not been approved.

**Abuse** is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid/Veteran Administration and other programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid/Veteran Administration program.

**Examples of Medicaid/Veteran Administration Abuse include:**

- Making errors when filling out the employee's timesheet and not immediately reporting the error to the Vendor F/EA FMS-Support Broker entity to remedy the situation.
- Being late in handing in Veteran/representative-employer related paperwork to the Vendor F/EA FMS-Support Broker entity.

#### **The difference between Fraud and Abuse**

Fraud is anything intentionally, purposefully or recklessly done to get something for your own benefit that you normally would not be entitled to. Abuse is anything that wasn't done intentionally or purposefully but was still completed incorrectly for your own benefit and not immediately reported.

**Medicaid/Veteran Administration Fraud and Abuse** is a crime against all taxpayers and is both a state and federal offense. All reports or allegations of fraud and abuse within the Veteran Directed Home and Community Based Services Program will be referred to the Veteran's Administration for possible criminal investigation. Veteran's suspected of Medicaid/Veteran Administration Fraud or Abuse also face termination from the Veteran Directed Home and Community Based Services Program.

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Veteran's Signature

Date

---

Authorized Representative Signature

Date

---

FMS Provider Signature

Date



**ARIS Solutions**

## HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

This notice describes how medical information about you may be used and disclosed and how we may obtain access to this information. Please review it carefully & keep for your records.

### DEFINITION OF MEDICAL INFORMATION

When ARIS Solutions/ VDH CBS Program refers to medical information, we mean protected health information (PHI). PHI is information that is individually identifiable health information including demographic information collected.

### USES AND DISCLOSURES OF PHI

**Health Care Operations-** Your medical information may be used and disclosed in connection with our health care operational including:

- *Case management and care coordination.*
- *Quality assessment and improvement activities and protocol assessment.*
- *Reviewing the competence or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification activities, and credentialing activities.*
- *Conducting legal services, compliance programs, fraud and abuse detection*
- *Business planning and development.*

**Additional disclosures-PHI may be disclosed;**

- *To another entity that has relationship with the organization for their health care operations relating to quality improvement and assessment activities, reviewing competence or qualifications of health care professionals.*
- *To other entities that assist us in conducting our health care operations.*

*We will not disclose your medical information to those persons or entities unless they agree to keep it protected.*



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## HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT continued...

**For the Public Benefit- as authorized by law for the following purposes:**

- *As required by law*
- *For public health activities, including disease and vital statistic reporting, FDA oversight, and for work related illness or injury*
- *To health oversight agencies*
- *In response to court and administrative orders*
- *To avert a serious threat to health and human safety*

*Your written authorization is required for all other uses and disclosures of your PHI. You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure you permitted to your revocation.*

### **YOUR RIGHTS**

**Access to your information** — *You have the right to inspect or obtain a copy of the medical information about you that is contained in a “designated record set”. The organization may ask you to submit your request in writing.*

**Accounting of disclosures** – *You have the right to receive a list of instances in which we or our associates disclosed your PHI for purposes other than health care operations or those authorized by you.*

**Confidential Communication** – *You have the right to request that we communicate with you about your PHI by a different means or at a different location. You make this request in writing.*

**Amending your PHI** – *You have the right to request that we amend your PHI contained in the “designated record set” if it is not correct or complete. We may require that this request be in writing.*

**Complaints** – *You have the right to file a complaint if you believe your privacy rights have been violated. You may file this complaint with ARIS Solutions/ VDHCB Program and/or the Secretary of the Department of Health and Human Services. All complaints to ARIS Solutions/ VDHCB Program must be made in writing. We support your right to protect your PHI.*

**\*\*PLEASE KEEP THIS FOR YOUR RECORDS\*\***



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## HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

*\*PLEASE SIGN/DATE & RETURN TO ARIS SOLUTIONS\**

*At ARIS Solutions/ VDHCB Program, we respect the confidentiality of your medical information and will protect information in a responsible manner. We have a privacy program in place that meets the requirements of HIPAA, the government legislation that sets standards for the privacy of medical information.*

*This notice will be effective for all medical information that we maintain, including medical information we created or received before \_\_\_\_\_ (date)  
\_\_\_\_\_(initials)*

## HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND CONSENT

*I acknowledge that I have been provided with a notice of privacy practices and have been advised of how health information about me may be used and disclosed by ARIS Solutions/ VDHCB Program and how may I obtain access to and control of this information.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*



**ARIS Solutions**

## CUSTOMER GRIEVANCE POLICY

At ARIS Solutions, we truly believe in providing best in class services to our customers. We aim to understand both our strengths and opportunities for improvement from our customer's point of view and work to continuously improve our services to best meet their needs.

Our Grievance Policy focuses on improving customer satisfaction by collecting feedback from all our customers and by putting action plans in place to address key issues, which are assigned to the relevant key staff for action.

We have a complaint tracking system which assigns each complaint with a number and allows us to track the aging and resolution of each complaint. The status of complaints is systematically reported to our Senior Management. Our goal is to ensure that all customer complaints are resolved within 30 days. The 30-day period will commence after all the necessary information sought from the customer is received.

The various channels through which our customers can contact us for any assistance with their grievances are listed below:

### **In the event your complaint is not addressed satisfactorily:**

If you are not satisfied with the response received at our helpline, you can escalate your grievance to:

Name: Theresa Danforth

Email: [theresad@arissolutions.org](mailto:theresad@arissolutions.org)

Fax: 802.295.9812

Telephone: 866.970.3301

(Monday to Friday 8:00 am to 4:00 pm EST)

Address: PO Box 4409, White River Jct., VT 05001

### **For further escalation of grievances, the same can be addressed to:**

Name: Jason Richardson

Email: [jasonr@arissolutions.org](mailto:jasonr@arissolutions.org)

Fax: 802.295.9812

Telephone: 802.280.1911

(Monday to Friday 8:00 am to 4:00 pm EST)

Address: PO Box 4409, White River Jct., VT 05001



# ARIS Solutions

**ARIS Solutions****Employer/Participant Information Form****NAME OF EMPLOYER**

Name \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_  
(Street) (Apt) (City) (State) (Zip)

Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

FEIN (If previously issued) \_\_\_\_\_

Relationship to Participant \_\_\_\_\_

**PARTICIPANT IS EMPLOYER**

**YES**

**NO**

*If yes please skip next section.*

**NAME OF PARTICIPANT**

Name \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (APT) (City) (State) (Zip)

Phone (\_\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Form <b>SS-4</b> (Rev. January 2010) Department of the Treasury Internal Revenue Service		<b>IN-GENERATIONS</b> <b>Application for Employer Identification Number</b> (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ See separate instructions for each line. ▶ Keep a copy for your records.		OMB No. 1545-0003 <b>EIN</b>				
Type or print clearly.	<b>1</b> Legal name of entity (or individual) for whom the EIN is being requested HHCSR							
	<b>2</b> Trade name of business (if different from name on line 1)		<b>3</b> Executor, administrator, trustee, "care of" name					
	<b>4a</b> Mailing address (room, apt., suite no. and street, or P.O. box) ARIS SOLUTIONS, PO BOX 4409		<b>5a</b> Street address (if different) (Do not enter a P.O. box.)					
	<b>4b</b> City, state, and ZIP code (if foreign, see instructions) WHITE RIVER JUNCTION, VT 05001		<b>5b</b> City, state, and ZIP code (if foreign, see instructions)					
	<b>6</b> County and state where principal business is located							
	<b>7a</b> Name of responsible party		<b>7b</b> SSN, ITIN, or EIN					
	<b>8a</b> Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>8b</b> If 8a is "Yes," enter the number of LLC members ▶					
<b>8c</b> If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No								
<b>9a</b> Type of entity (check only one box). <b>Caution.</b> If 8a is "Yes," see the instructions for the correct box to check. <input type="checkbox"/> Sole proprietor (SSN) <input type="checkbox"/> Estate (SSN of decedent) <input type="checkbox"/> Partnership <input type="checkbox"/> Plan administrator (TIN) <input type="checkbox"/> Corporation (enter form number to be filed) ▶ <input type="checkbox"/> Trust (TIN of grantor) <input type="checkbox"/> Personal service corporation <input type="checkbox"/> National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military <input type="checkbox"/> Other nonprofit organization (specify) ▶ <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises <input checked="" type="checkbox"/> Other (specify) ▶ HHCSR Group Exemption Number (GEN) if any ▶								
<b>9b</b> If a corporation, name the state or foreign country (if applicable) where incorporated		State		Foreign country				
<b>10</b> Reason for applying (check only one box) <input checked="" type="checkbox"/> Started new business (specify type) ▶ PERSONAL CARE/HOME CARE <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) ▶ <input type="checkbox"/> Banking purpose (specify purpose) ▶ <input type="checkbox"/> Changed type of organization (specify new type) ▶ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ <input type="checkbox"/> Created a pension plan (specify type) ▶								
<b>11</b> Date business started or acquired (month, day, year). See instructions.			<b>12</b> Closing month of accounting year JUNE					
<b>13</b> Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14. <table><tr><td>Agricultural</td><td>Household</td><td>Other</td></tr></table>			Agricultural	Household	Other	<b>14</b> If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. <input type="checkbox"/>		
Agricultural	Household	Other						
<b>15</b> First date wages or annuities were paid (month, day, year). <b>Note.</b> If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶								
<b>16</b> Check one box that best describes the principal activity of your business. <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input checked="" type="checkbox"/> Other (specify) ▶ Home & Community based personal care								
<b>17</b> Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HOME AND COMMUNITY BASED PERSONAL CARE TO VETERAN PARTICIPANT.								
<b>18</b> Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," write previous EIN here ▶								
Third Party Designee	Complete this section <b>only</b> if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.							
	Designee's name ARIS SOLUTIONS FISCAL AGENT		Designee's telephone number (include area code) 802-280-1911					
	Address and ZIP code PO BOX 4409 WHITE RIVER JUNCTION VT 05001		Designee's fax number (include area code) 802-295-9812					
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.			Applicant's telephone number (include area code)					
Name and title (type or print clearly) ▶			Applicant's fax number (include area code)					
Signature ▶			Date ▶					

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 1-2010)

Form **2678 Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

**Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.**

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

**Note.** This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

**For IRS use:****Part 1: Why you are filing this form...**

(Check one)

- ☒ You want to **appoint** an agent for tax reporting, depositing, and paying.  
☐ You want to **revoke** an existing appointment.

**Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.****1 Employer identification number (EIN)**

		-									
--	--	---	--	--	--	--	--	--	--	--	--

**2 Employer's or payer's name**  
(not your trade name)
**3 Trade name** (if any)
**4 Address**


**Number** **Street** **Suite or room number**

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

**City** **State** **ZIP code**

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Foreign country name

Foreign province/county

Foreign postal code

**5 Forms for which you want to appoint an agent or revoke the agent's appointment to file.** (Check all that apply.)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
--	---------------------------------------	--

Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)\*



Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)



Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)



Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)



Form 945 (Annual Return of Withheld Federal Income Tax)



Form CT-1 (Employer's Annual Railroad Retirement Tax Return)



Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)



\*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

- ☒ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

**X Sign your name here**

Print your name here

Print your title here

 HHCSR

Date

 /  / 

Best daytime phone

**Now give this form to the agent to complete.** ➡

**Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.****6 Agent's employer identification number (EIN)**

3	6	—	4	8	5	3	2	1	5
---	---	---	---	---	---	---	---	---	---

**7 Agent's name** (not trade name)

ARIS SOLUTIONS FISCAL AGENT- INDIANA

**8 Trade name** (if any)

ARIS SOLUTIONS FISCAL AGENT- INDIANA

**9 Address**

PO BOX 4409

Number

Street

Suite or room number

WHITE RIVER JUNCTION

City

VT

State

05001

ZIP code

Foreign country name

Foreign province/county

Foreign postal code

☒ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

**X Sign your name here**

Print your name here

JASON RICHARDSON

Print your title here

CHIEF OPERATING OFFICER

Date

/ /

Best daytime phone

802-280-1911

Form **2678** (Rev. 8-2014)

Form **8821**

(Rev. March 2015)

Department of the Treasury  
Internal Revenue Service**Tax Information Authorization**► Information about Form 8821 and its instructions is at [www.irs.gov/form8821](http://www.irs.gov/form8821).

► Do not sign this form unless all applicable lines have been completed.

► Do not use Form 8821 to request copies of your tax returns  
or to authorize someone to represent you.

OMB No. 1545-1165

For IRS Use Only

Received by:

Name \_\_\_\_\_

Telephone \_\_\_\_\_

Function \_\_\_\_\_

Date \_\_\_\_\_

**1 Taxpayer information.** Taxpayer must sign and date this form on line 7.

Taxpayer name and address

Taxpayer identification number(s)

Daytime telephone number

Plan number (if applicable)

**2 Appointee.** If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ► ☐

Name and address

ARIS SOLUTIONS FISCAL AGENT  
PO BOX 4409  
WHITE RIVER JUNCTION, VT 05001

CAF No. \_\_\_\_\_

PTIN \_\_\_\_\_

Telephone No. 802-280-1911

Fax No. 802-295-9812

Check if new: Address ☐ Telephone No. ☐ Fax No. ☐**3 Tax Information.** Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
EMPLOYMENT	941, 940, 941R, 941X, W2, W3	2018-2021	TAX LIABILITY
	W2C		

**4 Specific use not recorded on Centralized Authorization File (CAF).** If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ► ☐**5 Disclosure of tax information** (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):**a** If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ► ☒**Note.** Appointees will no longer receive forms, publications, and other related materials with the notices.**b** If you do not want any copies of notices or communications sent to your appointee, check this box . . . . . ► ☐**6 Retention/revocation of prior tax information authorizations.** If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ► ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

**7 Signature of taxpayer.** If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

► IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

► DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature

Date

HHCSR

Print Name

Title (if applicable)





State Form 2837 (R9 / 3-15)  
INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT  
10 N Senate Ave RM SE 202  
Indianapolis, IN 46204-2277  
Confidential record pursuant To IC 4-1-16, IC 22-4-19-6

**IMPORTANT:** Employer registration should be submitted on-line at <https://uplink.in.gov/ESS/ESSLogon.htm> on or before the due date of the employer's first quarterly report. If the employer is unable to submit an on-line application and disclosure statement, a copy of this form, SF 2837, must be attached to the employer's first quarterly contribution report (UC1S). Failure to timely register an account or to complete the application and disclosure statement accurately may result in civil penalties as described in IC 22-4-11.5-9 being assessed to the Employer and / or to the non-employer Agent. Please go to [www.in.gov/dwd/SUTA.htm](http://www.in.gov/dwd/SUTA.htm) for additional information or clarification.

## SECTION THREE – DISCLOSURES AND CERTIFICATION OF INFORMATION

Provide the name of the person in this organization that should be notified in the event of an audit or investigation. ***Not a third party provider***

First Name         Last Name

What is this person's Social Security Number? ***Mandatory disclosure***

Does this business share ownership, management, or control with any current or former Indiana Business? ☐ Yes ☒ No

Please identify the related business: SUTA #       FEIN

Name

IMPORTANT: If you have additional business relationships to disclose, please complete the related business disclosure form SF 28804.

What is the NAICS that best describes this entity? NAICS codes can be found at <http://www.census.gov/eos/www/naics/>

Code  8  1  2  9  9  0 Key Word(s) / Description  o  t  h  e  r   p  e  r  s

Additional Keywords  c  a  r  e   s  e  r  v  i  c  e  s

Provide the name and contact information for the person who prepared this form for signature.

First Name  E  M  I  L  I  E   Last Name  D  O  N  K  A

Telephone  8  6  6  -  9  7  0  -  3  3  0  1  Agent ☒ Employee ☐

Preparer's Signature: \_\_\_\_\_ Date   /   /

Provide the name of the person who is the responsible party for registration of this entity. ***Do not identify a third party Agent.***

First Name         Last Name

Telephone     -     -      Title HHCSR

Responsible Party's Signature: \_\_\_\_\_ Date   /   /

IMPORTANT: By signing this form, you are certifying that the information contained herein is true and accurate to the best of your knowledge and belief. You further affirm that you are a person of sufficient authority with regard to the named entity to file this document and to bind the business by the information provided including all required attachments and disclosures as indicated.

***Third party providers:*** This form should not contain third party provider information for any required response except the preparer signature, if applicable. Employers can designate correspondence agents or external authorized users for Indiana SUTA purposes only via ESS as described in 646 IAC 5-2-15. Third party providers are hereby notified that submitting this form or any ESS registration where the agent self identifies as the responsible party for the employer is specifically prohibited and is a violation of the Act as described in IC 22-4-11.5-9.

Mail completed forms to: IDWD – Employer Status Reports  
10 N Senate Ave Rm SE 202  
Indianapolis, IN 46204-2277

Fax: 317-233-2706  
Questions: 800-437-9136 (2)  
Handbook: [www.in.gov/dwd](http://www.in.gov/dwd)

Indiana Department of Revenue  
**Business Tax Application****A separate application is required for each business location.**To file this application online, visit:  
<https://secure.in.gov/apps/dor/bt1>**Section A: Taxpayer Information (see instructions on page 1)**  
Please print legibly or type the information on this application.1. Federal Identification Number (FID):  
\_\_\_\_\_2. If this business is currently registered with the Department of  
Revenue, enter your Taxpayer Identification Number (TID):  
\_\_\_\_\_

3. Name of contact person responsible for filing tax forms.

4. Contact person's daytime telephone number:  
A \_\_\_\_\_ B Ext. \_\_\_\_\_5. Check (only one) reason for filing this application: ☐ A Starting New Business ☐ B Business Under New Ownership ☐ C To Change Type of Organization  
☐ D To Add Location to Existing Account ☐ E To Register for Other Type(s) of Tax ☐ F Other \_\_\_\_\_6. Owner name, Legal name, Partnership name, Corporate name or  
Other entity name: ☐ A Check if foreign address (See instructions)B \_\_\_\_\_  
If sole owner (last name, first name, middle initial, Suffix)  
C \_\_\_\_\_  
Primary Address: D \_\_\_\_\_  
City: E \_\_\_\_\_  
State: F \_\_\_\_\_ Zip Code: G \_\_\_\_\_  
County: H \_\_\_\_\_  
Email Address: I \_\_\_\_\_7. Business trade name or DBA and physical location: (This name and  
address is for the business location.) ☐ A Check if foreign address  
(See instructions)Name: B \_\_\_\_\_  
P.O. Box numbers cannot be used as a business location address.  
Street Address: C \_\_\_\_\_  
City: D \_\_\_\_\_  
State: E \_\_\_\_\_ Zip Code: F \_\_\_\_\_  
County: G \_\_\_\_\_ Township: H \_\_\_\_\_  
Business Location  
Telephone Number: I \_\_\_\_\_ J Ext. \_\_\_\_\_

veteranpayroll@arissolutions.org

8. Check the type of organization of this business: ☐ A Sole Proprietor ☐ B Partnership ☐ C LLP ☐ D LP ☐ E Corporation ☐ F S Corp  
☐ G LLC ☐ H Nonprofit ☐ I Fed Govt ☐ J Other Govt ☐ K Other \_\_\_\_\_9. Indiana Secretary of State Control # \_\_\_\_\_ See [www.in.gov/sos/](http://www.in.gov/sos/) for requirements.

10. All corporations answer the following questions: Otherwise, proceed to Question 11.

A. State of Incorporation:

B. Date of Incorporation:

Month Day Year

C. State of Commercial Domicile:

D. If not incorporated in Indiana, enter the  
date authorized to do business in Indiana.

Month Day Year

E. Accounting period  
year ending date:

Month Day

11. North American Industry Classification System  
(NAICS): Please enter a primary and any  
secondary code(s) that may apply.**PRIMARY**12. Owner, Partners, or Officers (Attach separate sheet if necessary.) **Social Security Numbers are required in accordance with IC 4-1-8-1.**

A Social Security Number	B Last Name	C First Name	D Middle Initial	E Suffix	F Title	G Street Address	City	State	Zip Code
1									
2									
3									

13. Tax(es) to be Registered for this Business Location (Check all that apply.)

- |   |   |
|---|---|
| A Withholding Tax (Complete Section C.)                 | E Sales Tax (Complete Section B for a Registered Retail Merchants Certificate.) |
| B County Innkeepers Tax (Complete Section E.)           | F Out-of-State Use Tax (Complete Section B.)                                    |
| C Food and Beverage Tax (Complete Section D.)           | G Private Employment Agency (See instructions on page 2.)                       |
| D Motor Vehicle Rental Excise Tax (Complete Section F.) | H Tire Fee (Complete Section G.)  |

### Section H: Signature Section

Contact the Department at (317) 233-4015 for more information regarding this application.

I hereby certify that the statements are correct.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

This application **must** be signed by the owner, general partner, corporate officer, or resident agent **before it will be accepted by the Department.** (IC 6-8.1-3-4)

**Note:**

Failure to remit sales tax due and/or income tax withheld is a felony punishable by imprisonment, a fine of \$10,000 plus a 100-percent fraud penalty.

**The partners or corporate officers are each personally, jointly and severally liable for the sales and use tax\* collected and the withholding tax withheld. These taxes are trust fund taxes and are not discharged in bankruptcy proceedings.**

***\*This includes: County Innkeepers Tax (CIT), Food and Beverage Tax (FAB), Tire Fee (TIF), and Motor Vehicle Rental and County Supplemental Excise Tax (MVR).***

**Mail To:**

Indiana Department of Revenue  
Tax Administration Processing  
P. O. Box 6197  
Indianapolis, IN 46206-6197

**Private Employment Agencies Only**

**Mail To:**

Indiana Department of Revenue  
Licensing Section  
100 N. Senate Room N281  
Indianapolis, IN 46204

For additional information about private  
employment agencies:  
Call (317) 232-5977

Indiana Department of Revenue  
**POWER OF ATTORNEY****1. Taxpayer Information**

<b>*Taxpayer(s) Name(s)</b>		DBA Name(s) (if applicable)	
<b>Address</b> <input type="checkbox"/> New Address?			
<b>City</b>		<b>State</b>	<b>Zip Code</b>
<b>Telephone Number</b>			

**2. Identification Numbers**

\*Indiana Taxpayer Identification Number (10 digits)

or

Employer Identification Number

--	--	--	--	--	--	--	--	--	--

	—	
--	---	--

**Social Security Number**

Spouse's Social Security Number

--	--	--

--	--	--

Hereby appoint(s) the following:

**3. Representative Information**

<b>*Individual Representative Name</b>			Additional Individual Representative Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Telephone Number	Email		Telephone Number	Email	
Additional Individual Representative Name			Additional Individual Representative Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Telephone Number	Email		Telephone Number	Email	

**4. Firm/Vendor Information**

Firm/Vendor Name (*if applicable)		
Address		
City	State	Zip Code
Telephone Number	Email	

If firm or vendor, list representative(s) name, telephone number and email.

Representative(s) Name	Telephone Number	Email
		THERESAD@ARISSOLUTIONS.ORG

### 5. General Authorization

☐ I authorize the listed representative(s), in addition to anything otherwise authorized on this form, to represent me regarding any matters with the Indiana Department of Revenue regardless of tax years or income periods. I understand that this authority will expire 5 years from the date this POA is signed or a written and signed notice is filed revoking this authorization.

### 6. Tax Type(s) (Not applicable if box is checked in question 5 above)

\*Type of Tax

(Income, Withholding, Sales, etc.)

\*Year(s)/Period(s)

☐ Current Year ☐ Specify

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I acknowledge that the designated representative has the authority to receive confidential information and full power to perform on behalf of the taxpayer in tax matters related to this Power of Attorney. This authority does not include the power to receive refund checks.

I acknowledge that actions taken by the designated representative are binding, even if the representative is not an attorney. Proceedings cannot later be declared legally defective because the representative was not an attorney.

If I am a corporate officer, partner, or fiduciary acting on behalf of the taxpayer, I certify that I have authority to execute this Power of Attorney on behalf of the taxpayer.

### 7. Authorizing Signature

\*Signature \_\_\_\_\_

\*Date \_\_\_\_\_

\*Printed Name \_\_\_\_\_

Title \_\_\_\_\_

\*Telephone Number \_\_\_\_\_

Email \_\_\_\_\_

**\*Required fields - if not complete, this form will be returned to sender.**

*\*Per Indiana Biz File website ALL Indiana "Sole Proprietorships" are required to file at the County Recorder's Office. A small fee will need to be paid upon filing, please contact your specific Recorder to verify what forms of payment are accepted at that specific office.*

## IN COUNTY RECORDERS TELEPHONE NUMBERS

<b>ADAMS COUNTY</b> 260-724-5343	<b>ELKHART COUNTY</b> 574-535-6757
<b>ALLEN COUNTY</b> 260-449-7165	<b>FAYETTE COUNTY</b> 765-825-3051
<b>BARTHOLOMEW CO.</b> 812-379-1520	<b>FLOYD COUNTY</b> 812-948-5430
<b>BENTON COUNTY</b> 765-884-1630	<b>FOUNTAIN COUNTY</b> 765-793-2431
<b>BLACKFORD CO.</b> 765-348-2207	<b>FRANKLIN COUNTY</b> 765-647-5131
<b>BOONE COUNTY</b> 765-482-3070	<b>FULTON COUNTY</b> 574-223-2914
<b>BROWN COUNTY</b> 812-988-5462	<b>GIBSON COUNTY</b> 812-385-3332
<b>CARROLL COUNTY</b> 765-564-2124	<b>GRANT COUNTY</b> 765-668-6559
<b>CASS COUNTY</b> 574-753-7810	<b>GREEN COUNTY</b> 812-384-2020
<b>CLARK COUNTY</b> 812-285-6235	<b>HAMILTON COUNTY</b> 317-776-9618
<b>CLAY COUNTY</b> 812-448-9005	<b>HANCOCK CO.</b> 317-477-1142
<b>CLINTON COUNTY</b> 765-659-6320	<b>HARRISON COUNTY</b> 812-738-3788
<b>CRAWFORD CO.</b> 812-338-2615	<b>HENDRICKS CO.</b> 317-745-9224
<b>DAVIESS CO</b> 812-254-8675	<b>HENRY COUNTY</b> 765-529-4304
<b>DEARBORN COUNTY</b> 812-537-8817	<b>HOWARD CO.</b> 765-456-2210
<b>DECATUR COUNTY</b> 812-663-4681	<b>HUNTINGTON CO.</b> 260-358-4848
<b>DEKALB COUNTY</b> 260-925-2112	<b>JACKSON COUNTY</b> 812-358-6113
<b>DELAWARE CO.</b> 765-747-7804	<b>JASPER COUNTY</b> 219-866-4923
<b>DUBOIS COUNTY</b> 812-481-7067	<b>JAY COUNTY</b> 260-726-6940

**JEFFERSON COUNTY**

812-265-8900

**JENNINGS COUNTY**

812-352-3053

**JOHNSON COUNTY**

317-346-4385

**KNOX COUNTY**

812-885-2508

**KOSCIUSKO COUNTY**

574-372-2362

**LAGRANGE COUNTY**

260-499-6320

**LAKE COUNTY**

219-755-3740

**LAPORTE CO.**

219-326-6808 ext.2280

**LAWRENCE COUNTY**

812-275-4139

**MADISON COUNTY**

765-641-9613

**MARION COUNTY**

317-327-4020

**MARSHALL CO.**

574-935-8513

**MARTIN COUNTY**

812-247-2420

**MIAMI COUNTY**

765-472-3901 ext. 222

**MONROE COUNTY**

812-349-2520

**MONTGOMERY CO**

765-364-6415

**MORGAN COUNTY**

765-342-1077

**NEWTON COUNTY**

219-474-6081 ext. 125

**NOBLE COUNTY**

260-636-2672

**OHIO COUNTY**

812-438-3369

**ORANGE COUNTY**

812-723-7107

**OWEN COUNTY**

812-829-5013

**PARKE COUNTY**

765-569-3419

**PERRY COUNTY**

812-547-4261

**PIKE COUNTY**

812-354-6747

**PORTER COUNTY**

219-465-3465

**POSEY COUNTY**

812-838-1314

**PULASKI CO**

574-946-3844

**PUTNAM COUNTY**

765-653-5613

**RANDOLPH COUNTY**

765-584-7300

**RIPLEY COUNTY**

812-689-5808

**RUSH COUNTY**

765-932-2388

**ST. JOSEPH COUNTY**

574-235-9525

**SCOTT COUNTY**

812-752-8442

**SHELBY COUNTY**

317-392-6370

**SPENCER CO.**

812-649-6013

**STARKE COUNTY**

574-772-9109

**STEUBEN COUNTY**

260-668-1000 ext. 1700

**SULLIVAN COUNTY**

812-268-4844

**SWITZERLAND CO.**

812-427-2544

**TIPPECANOE CO.**

765-423-9352

**TIPTON COUNTY**

765-675-4614

**UNION COUNTY**

765-458-5434

**VANDEBURGH CO**

812-435-5215



**VERMILLION CO.**

765-492-5003

**VIGO COUNTY**

812-462-3301

**WABASH COUNTY**

260-563-0661 ext. 253

**WARREN CO.**

765-762-3174

**WARRICK COUNTY**

812-897-6165

**WASHINGTON CO.**

812-883-4001

**WAYNE COUNTY**

765-973-9234

**WELLS COUNTY**

260-824-6507

**WHITE COUNTY**

574-583-5912

**WHITLEY COUNTY**

260-248-3106

## Electronic Timesheets Agreement

### I. About The Electronic Timesheets Module

- a. The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Employees, and Fiscal Intermediary staff can respectively view relevant timesheet information.
- b. Consumers, Employers and Employees will be able to use the system to both submit and approve timesheets electronically for payment by the Fiscal Intermediary.
- c. A Consumer is not required to have an Employer in order to use the system. But in cases where a Consumer does have an Employer and the Consumer approves the Employer to have access to the Electronic Timesheets Submission Interface, both the Consumer and his/her Employer will have identical abilities to enter and approve timesheets for payment. If the Consumer does not feel comfortable with the electronic interface, the Employer has the ability to handle all of the Consumer's timesheet submission and approval responsibilities.

### II. Terms and Conditions

*By signing below, you are agreeing to the following Terms and Conditions:*

- a. The Consumer and/or his/her Employer and the Employee must have valid e-mail addresses that they access frequently.
- b. The Consumer, his/her Employer (if applicable) and the Employee agree to use the Electronic Timesheets Submission Interface as a method of submitting timesheets.
  - i. Signing this Agreement does not require you to only use the Electronic Timesheets Submission Interface. Other methods of submitting time, such as faxing or mailing, are still acceptable.
- c. A timesheet may not be submitted electronically if the Consumer and the Employee have not both signed and agreed to use the Electronic Timesheets Submission Interface via this Agreement.
  - i. If the Consumer approves their Employer to use the system, then the Employer must also sign this Agreement.
- d. An individual Electronic Timesheets Agreement is required for each Consumer/Employee relationship that chooses to use the Electronic Timesheets Submission Interface.
  - i. This is true even if the Consumer or Employee is already using the Electronic Timesheets Submission Interface in another Consumer/Employee relationship.

Program (Circle one): North Carolina      VDP      VOICE      SWIRCA      Generations

**Consumer Name:** \_\_\_\_\_ **Consumer E-mail:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ **Employer E-mail:** \_\_\_\_\_

**Consumer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* Note all fields in RED are required. Forms not completed in full will be returned.**

**Please print very clearly and legibly, or processing could be delayed.**

## About the Electronic Timesheets Module

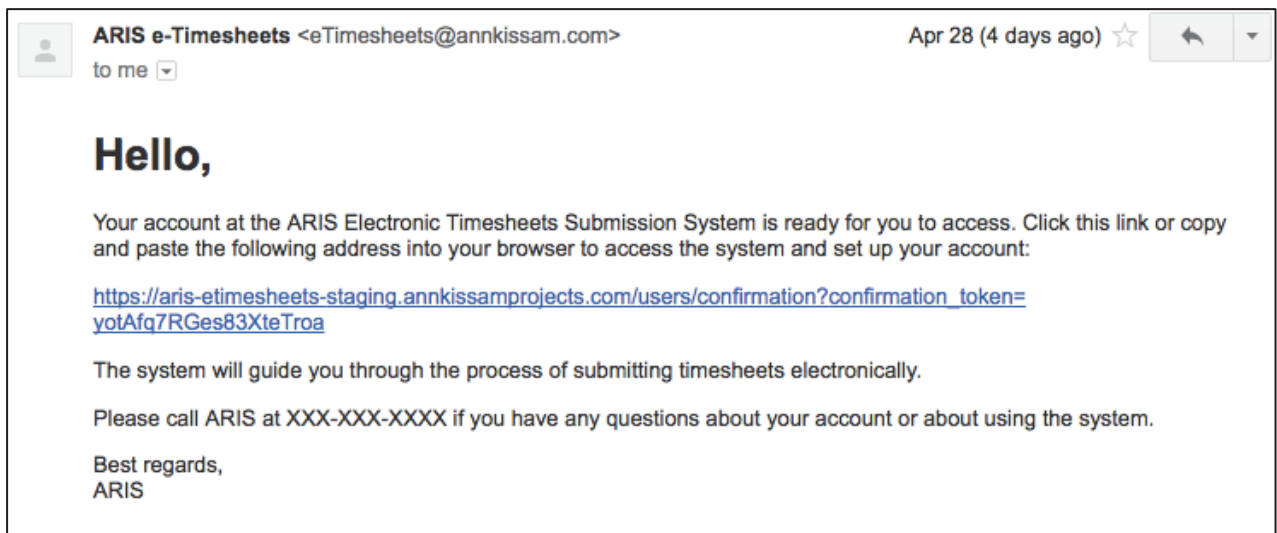
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

## Electronic Timesheets Agreement

In order to use the Electronic Timesheets Submission interface, a Consumer, their Representative or Employer (if applicable) and their Employee must sign an Electronic Timesheets Agreement which states that they both have valid e-mail addresses, and agree to use the electronic timesheets submission interface as a method of submitting time.

## Getting Started

1. An admin will create a user for the Consumer, Employer, Employee and Representative (if applicable).
2. The Consumer, Employer, Employee and Representative (if applicable) will each receive an e-mail alerting them that their account has been set up, and instructions for activating this account. Each user will click a one-time login link that expires after access to set up a password.



- Each user will be prompted to accept the Terms of Service, and set up a password for their account.

**Electronic timesheets user**  
**Terms of Service**


**USE OF USER ID AND PASSWORD:**  


1. If you register and/or set up an account on the Electronic Timesheets System Interface, you will be solely responsible for maintaining the confidentiality of your Registration Information. You may not authorize others to use your Registration Information. You may not sub-license, transfer, sell or assign your Registration Information and/or this Agreement to any third party. Any attempt to do so will be null and void and shall be considered a material breach of this Agreement.


2. You are solely responsible for all usage or activity on your account including, but not limited to, use of the account by any person who uses your Registration Information, with or without authorization, or who has access to any computer on which your account resides or is accessible.

3. If you have reason to believe that your account is no longer secure (for example, in the event of a loss, theft or unauthorized disclosure or use of your Personal Identifiable Information stored on the Electronic Timesheets System Interface), you must promptly change the affected Registration Information by using the appropriate update mechanism on the Electronic Timesheets System Interface, if available, or notify ARIS.

Please set your password for your account here.

 **New Password**

 **Confirm Password**



☐ I have read and accept the above terms of service.

**Submit**

- Once each user accepts the Terms of Service and creates a password, he or she may start using the system.



# WHAT EMPLOYERS NEED TO KNOW

*Author(s): Lucia Cucu, J.D.*

**Acknowledgements:** Lucia Cucu would like to acknowledge Merle Edwards-Orr and Mollie Murphy for their valuable contribution to this document. The detailed review and insightful comments they provided strengthened this resource.

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## **How to Protect Yourself and Your Worker: A Guide for Employers**

Being an employer brings not only rights but also responsibilities. This guide describes a few important issues that every employer should know about.

### **Maintaining a Safe Workplace**

It is important to keep your home safe for your employee. Slips and falls are a common cause of injuries, so you should clean up or warn your employee of spills and wet surfaces, and keep stairs and flooring in good repair. If you have pets in your home, make sure they cannot bite or scratch your employee.

### **Making Hiring and Firing Decisions**

#### **Terminating Employees**

Do not hesitate to terminate an employee who does not meet your needs. Most employment relationships are considered employment “at will,” which means you can terminate an employee for any reason or no reason at all, so long as your reason is not discriminatory, retaliatory (see discussion below) or otherwise unlawful.

#### **Avoiding Promises about the Length of Employment**

To avoid a claim for breach of contract, do not make any promises to your employee that you will keep him employed for a certain period of time or that you would only fire him for a specific reason. Remember that a contract does not always have to be in writing to be legally binding. Spoken statements and promises can sometimes create legal obligations.

#### **Avoiding Illegal Discrimination and Retaliation**

In many states it is illegal to discriminate against employees based on certain factors, which can include race, color, religion, sex, national origin, marital status, sexual orientation. This means that you must not hire, fire, or harass employees based on such factors. While your employee is with you, be careful not to express any personal opinions that could be interpreted as discriminatory. Even if you are in your own home, the home is considered a workplace while your employee is there, and workplace discrimination and harassment are prohibited by law.

Do not allow friends or family to behave in ways that could be considered discriminatory or harassing towards your employee. As the employer, you could be held responsible for their behavior if you allow it to continue.

Sexual harassment is also illegal. It includes unwelcome sexual advances that can be physical or verbal, such as offensive comments or gestures that create a hostile environment. Remember that the harasser can be someone other than the employer, such as a guest visiting your home or someone who lives with you.

It is also illegal to fire employees in retaliation for reporting a crime or irregularity. For example, if an employee believes that an employer is misusing Medicaid funds and reports it to the authorities, it would be illegal to fire the employee in retaliation.

### **Providing References for Former Employees**

Be careful when talking about your reasons for terminating employees, because you could risk a claim of discrimination or defamation (saying things about the employee who harms them). If you are asked for a reference about a former employee and cannot provide a positive one, it is safest not to provide a reference at all.

## **What Family Members and Authorized Representatives Need to Know**

### **Your Duty as Representative**

In participant-directed programs, usually the participant (the person receiving services) is the employer. It is not unusual, however, for the participant to be unable or unwilling to serve as the employer. In those cases, the participant will designate a “representative” to serve as the employer. If you are designated as an authorized representative, you have a *fiduciary* duty to the participant. “Fiduciary” means you must always act in the best interest of the participant and not in your own interest. Program funds must always be spent for the participant’s benefit, not your own benefit.

### **Hiring and Training Employees**

If the participant is likely to injure himself or others, you have a duty to warn employees of the risk and instruct them how to best handle it. Make sure to hire only employees who can deal with situations that arise. Ask them to confirm that they understand the risks and are willing and able to handle them.

If you are a parent, you must exercise reasonable care to control your minor child as best as you can, even if you are not listed as an authorized representative for the child. It is important to hire employees who are able to deal with any risks they may encounter when caring for your child. You should warn employees ahead of time of risks, and explain how to best handle situations that may come up.

### **Mandatory Reporter Duty**

As an authorized representative, you may have a legal duty to report to the authorities if you suspect or notice that the participant is being abused by a family member, an employee, or some other person. Many states have “mandatory reporter” laws that could require you to report abuse of a child, an elderly adult or a person with a disability. You may have a duty to report the abuse even if the abuser is a member of your own family or the participant’s family.

## **Worker's Compensation Insurance**

It is important to maintain a worker's compensation insurance policy, because such insurance will pay for claims if an employee is injured on the job.

If an employee is injured while at work, the employer is liable even if the injury is not the employer's fault. For example, if your employee drives to the grocery store on your behalf and is injured when a careless driver hits her car, the employee could ask you for compensation even though you could not have prevented the accident. This is because employers have to compensate employees for injuries sustained on the job. A worker's compensation insurance policy will pay for such claims.

## **Liability Insurance**

Worker's compensation will pay when your employee is injured, but what happens when someone else is injured? As an employer you may be liable when your employee injures someone else, even if the injury is not your fault. For example, if your employee causes a car accident while driving you to an appointment and injures a third party, the third party could sue you because your employee caused the accident while on the job.

Employment-related claims like wrongful termination, discrimination, or defamation are another source of liability that is not covered by worker's compensation insurance.

Some homeowner's, renter's, or liability insurance policies will cover such claims. However the terms of insurance policies vary, so you should read the terms and consult with an insurance agent before you start your participant direction program. You may consider an addition to your homeowner's or renter's policy, or a separate liability insurance policy, to be covered for liability risks related to domestic employees.